STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Susan S. Wiedenkeller, PA-C	)	Docket Nos. MPN 159-0803 MPN 79-1001

STIPULATION AND CONSENT ORDER

NOW COME Susan S. Wiedenkeller, PA-C (Respondent), and the State of Vermont, by and through Attorney General William H. Sorrell and the undersigned Assistant Attorney General, James S. Arisman, and agree and stipulate as follows:

1. Susan S. Wiedenkeller, PA-C, holds Vermont Physician Assistant Certificate Number 055-0030389, issued by the Board of Medical Practice on January 30, 1998. Respondent was certified by the Board for practice as a physician assistant (hereinafter "PA") at the Gifford Medical Center in Randolph, Vermont.

2. Jurisdiction vests with the Vermont Board of Medical Practice (Board) by virtue of 26 V.S.A. §§ 1311, 1353, 1354, 1361, 1398, 1733, 1736, and 1737.

I. Background.

3. This Stipulation and Consent Order concerns two matters reviewed by the Board of Medical Practice involving Respondent Wiedenkeller. One matter involved patient care and is discussed below. The other matter is discussed in Section IV of this document, beginning on page 10.

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A. Care of Patient by Respondent in November 2000.

4. The Board of Medical Practice opened Docket No. MPN 79-1001 following receipt of information regarding PA Wiedenkeller's care on or about November 7, 2000 of a

24-year old female patient (hereinafter referred to as Patient A) at the emergency department of Gifford Medical Center in Randolph, Vermont.

5. The emergency department admission form for Patient A indicates that she arrived at approximately 9:50 p.m. on or about November 7, 2000. Patient A complained upon arrival of having experienced three days of fever in a range of 99° to 104°, an instance of vomiting, lightheadedness, and headache. The patient denied any recent infection. She reported that she was 8½ weeks pregnant.

6. A note on intake form also indicated that the patient had recently returned from abroad, from Ghana.[1]

7. Respondent reviewed the admission form, examined the patient and spoke with her. Respondent recorded Patient A's chief complaint in medical records as "Fever and dysuria". Respondent recorded that the patient had presented "with a 3 day history of intermittent, spiking fever associated with dysuria and frequency." And, "The patient states that fever has spiked up to a 104 F despite treatment with Aleve."[2]

8. Patient A provided a urine specimen that was sampled by dipstick and produced a positive result suggestive of a urinary tract infection. Wiedenkeller Deposition, 3/26/02, Transcript at 149 (hereinafter referred to as "Wiedenkeller Depo. Tr. at __"). Respondent recorded in the patient's chart, "Differential diagnoses include urinary tract infection, pregnancy, viral syndrome." Respondent's "Clinical Impressions" were: 1) fever; and 2) urinary tract infection. Respondent entered a diagnosis of "Antepartum UTI", i.e.,

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1. The emergency department intake form stated, "just ret'd from Guana." Respondent has stated that she understood this misspelled word to refer to the African nation of Ghana. Wiedenkeller Depo. Tr. at 129.
2. The patient's temperature at admission was recorded as 99.3°. The patient reported that she had taken Aleve at 8:30 p.m., i.e., approximately one hour and twenty minutes before her arrival at the hospital emergency room.

urinary tract infection. She prescribed a 7-day course of Amoxicillin, fluids, and rest. Respondent also wrote in discharge plan instructions that Patient A was to follow-up with an obstetrician if she was not "better" in two to three days, and "sooner if worse". The patient's hospital visit lasted just less than an hour. Respondent spent approximately 15 minutes with Patient A during this visit. Wiedenkeller Depo. Tr. at 85.

B. Patient's Subsequent Course.

9. Four days after her emergency room visit at Gifford Medical Center, Patient A died in Plainfield, Vermont, in her college dormitory room, apparently without having sought further medical care. An autopsy performed by the State's Office of the Chief Medical Examiner identified the cause of death as "Parasitemia and cerebral malaria due to: Plasmodium falciparum [malarial parasite] infection".

C. Parent's Allegations Regarding Care of the Patient.

10. The parents of Patient A alleged that Respondent (and others who had been involved in her care) failed to detect their daughter's malarial condition during her hospital visit. The parents alleged that Respondent did not meet the prevailing standard of medical care in treating their daughter. The parents litigated the matter, naming Respondent and several other practitioners as defendants.

11. The parent's allegations were considered by several physician reviewers. These reviews produced conflicting opinions as to whether or not Respondent had met the prevailing standard of medical care during the patient's emergency room visit. The parent's legal action was later settled through mediation. Respondent did not admit liability in the settlement.

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D. Respondent's Position.

12. Respondent Wiedenkeller has contended that she provided appropriate medical care during the patient's emergency room visit and that her treatment of Patient A met the prevailing standard of medical care. Respondent asserts that Patient A failed to disclose vitally important information while being treated, i.e., that the patient had not taken anti-malarial medications while traveling in Africa.

13. Respondent also has asserted that Patient A refused to undergo blood testing that could have diagnosed her malarial condition. Wiedenkeller Depo. Tr. at 102; 106-108; 120-121. Respondent recalls that during the hospital visit, she recognized that Patient A displayed some symptoms of malaria and understood that Patient A might have malaria.[3] Wiedenkeller Depo. Tr. at 101-103. However, as indicated, Respondent has stated that she did **not** test Patient A for malaria, by having blood slides prepared for microscopic examination, because the patient expressly "refused blood work". Wiedenkeller Depo. Tr. at 32-33; 87-88; 106-108; 150; 153.

II. Malaria: Transmission and Diagnosis.

14. Malaria is the most common "imported" disease in the United States, with approximately 1,000 such cases imported each year.[4] Increasing tourism and air travel have resulted in the escalating occurrence of malaria in industrialized countries among persons who

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3. Respondent has indicated that her academic preparation in Florida included study of insect-borne infectious diseases. She has stated that in the past she had treated 6 to 12 individual cases of malaria. Wiedenkeller Depo. Tr. at 18- 36; 199.

4. D.J. Gubler, *Resurgent Vector-Borne Diseases as a Global Health Problem*, Emerging Infectious Diseases, Centers for Disease Control and Prevention, July-Sept 1998.

have visited and returned from disease-endemic regions.[5] Travelers to sub-Saharan African countries, such as Ghana, are at "very high risk of malaria exposure". Statistics indicate that "[m]ore than 82 percent of imported malarial infections in U.S. citizens were contracted in Africa."[6]

15. Studies of febrile patients returning from tropical areas have found malaria to be the most frequent cause of such fever.[7] In non-endemic areas, such as the U.S. and Europe, the prompt and accurate detection of malaria in febrile returning travelers is deemed to be "critical" as these individuals are likely to be non-immune. Delay in diagnosis can be fatal.[8]

16. Care and treatment include taking a detailed history, including a complete travel history, as well as performing a physical examination of the febrile, returned traveler, followed by laboratory testing. "Malaria films must be performed and competently examined as a matter of urgency, if the patient has travelled through a malarious zone. If blood films

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5. T.C. Nchina, *Malaria: A Reemerging Disease in Africa*, Emerging Infectious Diseases, Centers for Disease Control and Prevention, July-Sept 1998. In 1998 it was estimated that more than 300 million cases of malaria occurred worldwide annually, with 90% of these in Africa. See also P. Martens and L. Hall, *Malaria on the Move: Human Population Movement and Malaria Transmission*, Emerging Infectious Diseases, Centers for Disease Control and Prevention, March-April 2000.

6. See G. Juckett, *Malaria Prevention in Travelers*, American Family Physician, May 1, 1999; and see McGill University Centre for Tropical Medicine, *Malaria Risk by Geographic Areas in Countries with Endemic Malaria*, March 21, 2000 (all of Ghana identified as area of malarial risk).

7. See e.g., J. Doherty, A Grant, A. Bryceson, *Fever as the Presenting Complaint of Travellers Returning from the Tropics*, QJM: International Medical Journal, April 1995; and J. MacLean, R. Lalonde, B. Ward, *Fever from the Tropics*, Travel Medical Advisor, May 1994.

8. *New Perspectives in Malaria Diagnosis*, World Health Organization, October 25-27, 1999 Joint Consultation.

9. *Fever in the International Traveller Initial Assessment Guidelines*, Canada Communicable Disease Report, Public Health Agency of Canada, April 1997. Most travelers with fever were reported following study to be unlikely to identify malaria as a possible explanation for their febrile condition.

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cannot be examined quickly and competently, the films or the patient should be referred as quickly as possible to a centre where this can be done."[9]

17. Examination of blood films is urgent because the greatest risk for clinical presentation of Plasmodium falciparum [malarial] infections is in the 12 weeks following the last, potential, infected mosquito exposure. Blood films need to be repeated even if the first films are negative.[10] Examination of thick and thin blood films is accomplished by a finger-stick and obtaining a drop of blood.

III. Respondent's Record Keeping.

18. Respondent has stated that she was aware from Patient A's intake form that the patient had returned from Ghana three weeks earlier. Wiedenkeller Depo. Tr. at 125-126; 146. Patient A reportedly stated while being examined that she had felt generally well until three days before her visit to the emergency department, when she began to experience dysuria, urinary frequency, low-grade fever and an episode of high fever.[11] Wiedenkeller Depo. Tr. at 104.

19. Respondent asked Patient A if she was "concerned about a foreign disease", Patient A reportedly answered "no" and then stated, "I think I have a UTI."[12] Wiedenkeller Depo. Tr. at 102-104. The patient added that she had been to Africa many times. Respondent inferred from the patient's responses that Patient A "was not concerned about

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10. *Fever in the International Traveller Initial Assessment Guidelines, supra.*

11. The patient presented with a temperature of 99.3°. However, Respondent noted from the intake form that the patient had taken Aleve an hour earlier. Wiedenkeller Depo. Tr. at 119-120; 131.

12. Respondent has stated that the patient was educated and that the patient herself suggested that she had a urinary tract infection. Wiedenkeller Depo. Tr. at 100-10; 105.

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malaria". Wiedenkeller Depo. Tr. at 104-107. Respondent during her medical training had learned that West Africa was an area in which malaria was endemic and that Ghana specifically was a high-risk area for malaria. Wiedenkeller Depo. Tr. at 21-23.

20. Respondent herself did not tell Patient A specifically that she, a physician assistant, was concerned that Patient A might have malaria.[13] Wiedenkeller Depo. Tr. at 102-103. Respondent also has stated that she did not offer the patient a pin prick blood test for malaria because the patient did not want and had refused any blood work.[14] Wiedenkeller Depo. Tr. at 107-108. Respondent has stated that she did not tell Patient A that only a pin prick and a droplet of blood would be required to test for malaria. Id.

21. Respondent specifically recalls that Patient A did not tell her that she had not taken anti-malarial prophylaxis while she was in Africa. Wiedenkeller Depo. Tr. at 126; and Wiedenkeller Response Letter of Jan. 15, 2002 re Docket No. MPN 70-1001. However, no entry appears in the medical records indicating that Respondent herself questioned the patient regarding the use of any such medication.[15]

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13. Respondent was aware she could consult by telephone with practitioners with expertise in insect-borne and tropical diseases, such as at the Dartmouth Hitchcock Medical Center or from staff at her own hospital. Wiedenkeller Depo. Tr. at 41-47; 148-149. Such consultation also would have been available from the Centers for Disease Control and Prevention in Atlanta that has maintained a 24-hour "Malaria Hot Line" since 1992.

14. Respondent has stated that she had wanted to perform a complete blood count and a basic chemistry study that would have required drawing a vial of the patient's blood. (These studies are not a means of detecting malaria.) Respondent has stated that she was concerned that Patient A might be suffering pyelonephritis, i.e., inflammation of the kidney and renal pelvis. Respondent has stated that she did tell Patient A that she was concerned regarding the possibility of pyelonephritis because "it's very dangerous in pregnant women." Wiedenkeller Depo. Tr. at 108-110.

15. Prior to traveling to Ghana Patient A indicated to another practitioner at another hospital in August 1999, according to records, that she would not take anti-malarial prophylaxis and refused any further suggestions and advice in this regard.

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22. Respondent discharged Patient A with a diagnosis of urinary tract infection. Respondent prescribed Amoxicillin based on this diagnosis. Respondent's written discharge plan states, "Patient is to begin a prescription for Amoxicillin 500 mg 3 times a day for 7 days. Fluids, rest, follow up with Obstetrician if not better in 2 to 3 days[,] sooner if worse." Respondent states that at discharge she also orally told the patient that she should be alert for repeated fever, continued malaise, dysuria, urinary frequency, and worsening of any symptom. Wiedenkeller Depo. Tr. at 100

A. Information Not Recorded by Respondent.

23. The State alleges here that the written medical records that Respondent prepared do not contain specific entries that would document important aspects of the care that Respondent has stated she provided to Patient A.

24. Notwithstanding the content of the discharge plan as described in Paragraph 22, above, Respondent has stated that she also told Patient A to come back to emergency care if she was not getting better within 24 hours or became febrile again. The State alleges here that no entry reflective of such purported oral advice appears anywhere in the patient's medical chart. Respondent agrees, based on review of the record that she did not document in writing this claimed oral instruction to the patient.

25. Respondent also agrees, based on review of the record, that (a) she did not include in writing in the patient's medical record an entry reflecting that she had recognized that the patient had presented at least some symptoms of malaria; and (b) that Respondent herself believed or understood that Patient A might have malaria.

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26. Respondent also agrees, based on review of the record, that she did not include in the record a notation that the patient while being examined had denied or displayed unconcern about the possibility of contracting a "foreign disease" because "she had been to Africa many times through a school program."

B. Refusal of "Blood Work" Not Documented by Respondent.

27. Respondent also agrees, based on review of the record, that she did not enter in writing in the patient's medical record that the patient had "refused blood work", i.e., testing that potentially could have diagnosed malaria through microscopic examination of blood smears on slides. Respondent agrees that she did not tell the patient that such blood testing for malaria would require only a pin prick of her finger.

C. Recent Return from Ghana Not Addressed in Medical Record.

28. Respondent also agrees, based on review of the record, that she did not personally include in writing in the patient's medical record, e.g., as part of her medical decision-making, any entry addressing the patient's recent return from Ghana. Respondent agrees that such information has medical significance and is of diagnostic significance.

D. Other Information Not Recorded.

29. Respondent also agrees, based on review of the record, that she did not include in writing in the patient's medical record an entry reflecting that she advised the patient that she might have pyelonephritis, that this condition "can be very dangerous", and that a complete blood count and basic chemistry analysis should be done to address this possibility. Respondent agrees, based on review of the record, that she also did not include a written entry to document that the patient declined to follow this specific recommendation.

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30. Respondent also agrees, based on review of the record, that she did not include in writing in the patient's medical record that she and the patient discussed the possible adverse side effects of medication that might be prescribed for the patient and that the patient had indicated that she "did not care what antibiotic" was prescribed for her and had asked for "something strong because I don't care."

IV. Respondent's Criminal Conviction.

A. Arson Charges.

31. Respondent was criminally charged by the State of Vermont on March 31, 2003 with arson in connection with a structure fire that occurred on or about September 13, 2002 at 103 Van Dyke Road, Strafford, Vermont, at a home owned by Respondent.

32. The dwelling in question was wholly consumed by fire. Respondent made a claim for and received an insurance settlement for the loss by fire of the dwelling and contents. Following review of the circumstances and certain information by the fire investigation unit of the Vermont State Police, including information obtained from telephone wiretaps, Respondent was charged on April 22, 2003 with (a) first degree arson (felony), 13 V.S.A. § 502; (b) burning to defraud an insurer (felony) 13 V.S.A. § 506; and (c) unlawful mischief (felony), 13 V.S.A. § 3701, in Orange District Court (Docket No. 203-4-03 Oecr).

33. Respondent subsequently took a leave of absence from practice as a physician assistant. Respondent also cooperated with the Board of Medical Practice when it began its investigation of this matter. On September 15, 2003, Respondent voluntarily agreed to cease and desist from practice as a physician assistant pending further investigation of this matter and further action by the Board.

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B. Respondent's Guilty Plea and Criminal Convictions.

34. Respondent Wiedenkeller on January 22, 2004 pled guilty in Vermont District Court, Burgess, J., to: (a) first degree arson, 13 V.S.A. § 502, a felony; and (b) an amended charge of unlawful mischief, 13 V.S.A. § 3701, misdemeanor. The State dismissed the other felony charge of burning to defraud an insurer, 13 V.S.A. § 506. In pleading guilty, Respondent admitted that she set fire to and burned her own home. She affirmed during her plea colloquy that she committed these acts so as to receive insurance compensation for the structure and property destroyed by her.

35. Following Respondent's guilty plea, the court deferred sentencing for four years on the first-degree arson charge and placed Respondent on probation.[16] The court entered a sentence of actual incarceration on the unlawful mischief charge of 100 to 120 days and that sentence has been served in its entirety. Respondent also was ordered to perform 250 hours of community service as a condition of the deferred sentence agreement. Respondent paid financial restitution to all victims of her unlawful conduct and sent letters of apology to all public agencies that responded to the fire at her property.

36. Respondent has not practiced as a physician assistant since 2003.

V. Agreement.

37. Respondent wishes to continue her cooperation with the Board in the discharge of its public responsibilities. Respondent has met with the assigned Board

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16. If Respondent fulfills all conditions of the deferred sentence agreement, the arson charge will be dismissed on or about January 22, 2008, the adjudication of guilt on this charge will be stricken, and the public records in connection with the arson charge will be expunged.

investigative committee and has discussed at length the circumstances alleged in Paragraphs 31 to 36. Respondent has apologized and expressed remorse for her actions.

38. Respondent has not been the subject of prior disciplinary action by the Board. No specification of charges has been filed by the State in this matter.

A. Revocation.

39. Respondent recognizes and accepts the Board's responsibility for regulation of the field of medicine and protection of patients. Respondent wishes to bring the instant matters to closure and to continue her cooperation with the Board of Medical Practice. Now, therefore, Respondent acknowledges and agrees that the Vermont Board of Medical Practice, acting pursuant to its authority and the provisions of 26 V.S.A. § 1398, may enter an order **REVOKING** her physician assistant certification in the State of Vermont.

40. Respondent has carefully reviewed the State's allegations as set forth in this document. She disagrees with some allegations by the State or with some aspects of these allegations as they have been set forth. Respondent, however, enters here the following express admissions: (a) she admits, based on review of the record, that she did not include in writing in the patient's medical record that the patient had "refused blood work", i.e., microscopic examination of blood smears that would have been taken from the patient; see Paragraph 27, above; and (b) she admits to her criminal convictions on January 22, 2004, as described above in Paragraphs 31 through 35. Respondent agrees that the Board of Medical Practice may adopt and enter as its findings and/or conclusions the facts set forth in this paragraph, in Paragraph 27, and in Paragraphs 31 through 35, above.

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41. Respondent expressly acknowledges and agrees that her felony adjudication of guilt on the charge of first degree arson constitutes the necessary evidentiary basis for the Board to enter an order revoking her physician assistant certification under 26 V.S.A. § 1398 and that the Board may enter its conclusion of law to this effect. She agrees that following such revocation by the Board, any certification she may hold or has held as a physician assistant in the State of Vermont shall be wholly void and without any force or effect. Respondent understands and agrees that such action of revocation by the Board shall be final and unappealable.

B. Possibility of Future Vermont Certification.

42. Respondent further agrees that until the passage of at least five years, retroactive to the date of her formal agreement with the Board on September 15, 2003 (providing for her to cease and desist from practice), she shall not seek certification, recertification, or reinstatement in the state of Vermont as a physician assistant. Thus, the parties expressly agree that prior to September 15, 2008, the Board shall not accept, consider, or act upon any application, motion, or petition regarding certification from Respondent, regardless of circumstances. Respondent expressly agrees that prior to that date, the Board may and shall return to her, without action of any kind, any application, motion, or petition from her in this regard.

43. Respondent agrees that she voluntarily shall waive any right of confidentiality that she may possess as to the Board's investigative file in this matter in the event that she applies for licensure or certification in another jurisdiction at a later date.

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44. Respondent agrees and understands that any future consideration by the Vermont Board of Medical Practice of an application, petition, or motion from her with regard to certification shall be subject to the most careful review and scrutiny by the Board. Respondent acknowledges and agrees that she shall bear the burden of proof.

45. Respondent acknowledges and agrees that she shall provide all such information and documentation as the Board in its sole discretion may reasonably request for its review and consideration. Respondent agrees that she shall maintain her own records of pertinent information and documents for consideration by the Board in the event of any future application from her for certification. Respondent agrees that she shall undergo such evaluation or assessment as the Board may reasonably request as part of any review and consideration of an application from her.

46. Respondent acknowledges and agrees that the Board's review and consideration of any application, petition, or motion from her with regard to certification may consider, but shall not be limited to, factors such as her intervening employment history, continuing medical education, volunteer and other activities, community service, criminal history, probation and supervision history, involvement in care, treatment, and therapeutic counseling, evidence of rehabilitation, and any other relevant information. Respondent agrees that she shall sign such waivers and/or consents as to medical and other confidentiality as may be requested of her by the Board, its staff, or its agents, without limitation. Respondent shall bear any and all costs with regard to the purposes set forth in this and the preceding paragraph.

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47. Respondent acknowledges and understands that no promises of any kind have been made to her as to any action or decision that the Board of Medical Practice might take with regard to any future application, petition, or motion from her with regard to possible certification as a physician assistant.

48. Should the Vermont Board at a later date, after due consideration, and in its sole discretion, agree to issue a physician assistant certification to Respondent, she understands and agrees that such certification shall be designated as "conditioned" and shall be subject to specific practice conditions. These conditions may include, but shall not be limited to, those set forth below.

C. Possible Conditions; Acknowledgement by Respondent.

49. Respondent acknowledges and agrees that upon request she shall meet with the Board, its licensing committee, or any assigned investigative committee to discuss her ability to practice competently and safely, as well as to address possible terms and conditions of licensure that would regulate her practice activities. In this regard, Respondent agrees that she shall cooperate fully with the Board, its staff and agents, or its committees and provide such information and documents for Board review and consideration, as may be requested of her. Respondent agrees that she shall provide waivers and/or consents as to medical or other confidentiality as may be requested of her to permit the Board to carry out its licensing, compliance monitoring, and regulatory functions. Respondent agrees she shall provide a complete copy of this Stipulation and Consent Order to any licensing authority or any prospective employer in the medical field to which she may make application with regard to possible practice as a physician assistant.

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50. The Vermont Board of Medical Practice agrees upon approval of this Stipulation and Consent Order, that the matters involving Respondent that are currently open before the Board, i.e., Docket Nos. MPN 79-1001 and MPN 159-0803, shall be administratively closed by the Board. Thereafter, the Board will take no further action on these matters, absent non-compliance with the terms and conditions of this agreement by Respondent or the receipt of new information or evidence that may warrant further action by the Board.

D. Other Matters.

51. Respondent acknowledges that she is knowingly and voluntarily agreeing to this Stipulation and Consent Order. She acknowledges that she has had advice of counsel in this matter and is well satisfied with all such advice, counsel, and representation she has received. Respondent agrees and understands that by executing this document she is waiving such rights, as she may possess, to be served with formal charges, to challenge the jurisdiction and continuing jurisdiction of the Board in these matters, and to present evidence at a public hearing.

52. This Stipulation and Consent Order is conditioned upon its acceptance by the Vermont Board of Medical Practice. If the Board rejects any part of this document, the entire agreement shall be considered void. Respondent acknowledges and understands that this Stipulation and Consent Order is a matter of public record, shall become part of her permanent Board file, shall constitute an enforceable legal agreement, and may be reported to other licensing and/or certification authorities.

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53. In exchange for the action(s) by the Board, as set forth herein, Respondent expressly agrees to be bound by all terms and conditions of this Stipulation and Consent Order. Respondent is aware that upon approval, this agreement shall become an enforceable order of the Board of Medical Practice.

54. The parties therefore jointly agree that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable to the Vermont Board of Medical Practice, the Board may enter an order adopting all terms and conditions, findings, and conclusions of law herein, with such order by the Board expressly **REVOKING** the Vermont physician assistant certification of **RESPONDENT SUSAN S. WIEDENKELLER, P.A.**

Dated at Montpelier, Vermont, this 26th day of April 2005.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

by: James S. Arisman
JAMES S. ARISMAN
Assistant Attorney General

Dated at Hartford, Vermont, this 25 day of April, 2005.

Susan S. Wiedenkeller
SUSAN S. WIEDENKELLER, P.A.
Respondent

Dated at Rutland, Vermont, this 26 day of April, 2005.

Karen S. Heald
KAREN S. HEALD, ESQ.
Counsel for Respondent

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FOREGOING, AS TO SUSAN S. WIEDENKELLER, P.A.
APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

DATED: 5/14/08

ENTERED AND EFFECTIVE: May 14th, 2008

WIEDENKELLER STIP/CONSENT (REV ID: MED BD; JSA/AAG

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